



Health Reform in South Carolina

John Supra – August 15, 2013

Health Care Spending

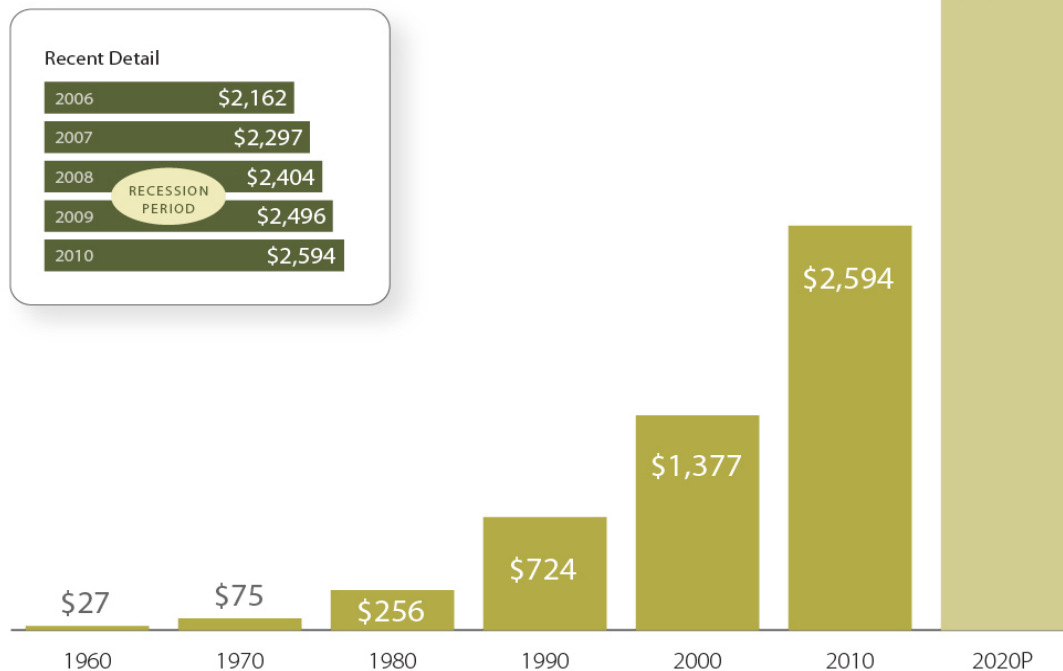
Constant Health Spending Growth



Health Spending

United States, 1960 to 2020, selected years

IN BILLIONS



Notes: Health spending refers to National Health Expenditures. Projections (P) include the impact of the Affordable Care Act.
Source: Centers for Medicare and Medicaid Services (CMS), Office of the Actuary, National Health Expenditure Data, 2012 release.

©2012 CALIFORNIA HEALTHCARE FOUNDATION

Total health care spending in the United States has nearly doubled or more every decade since 1960

In 2009, 2010 and 2011 health care spending grew 3.9% each year (record lows)

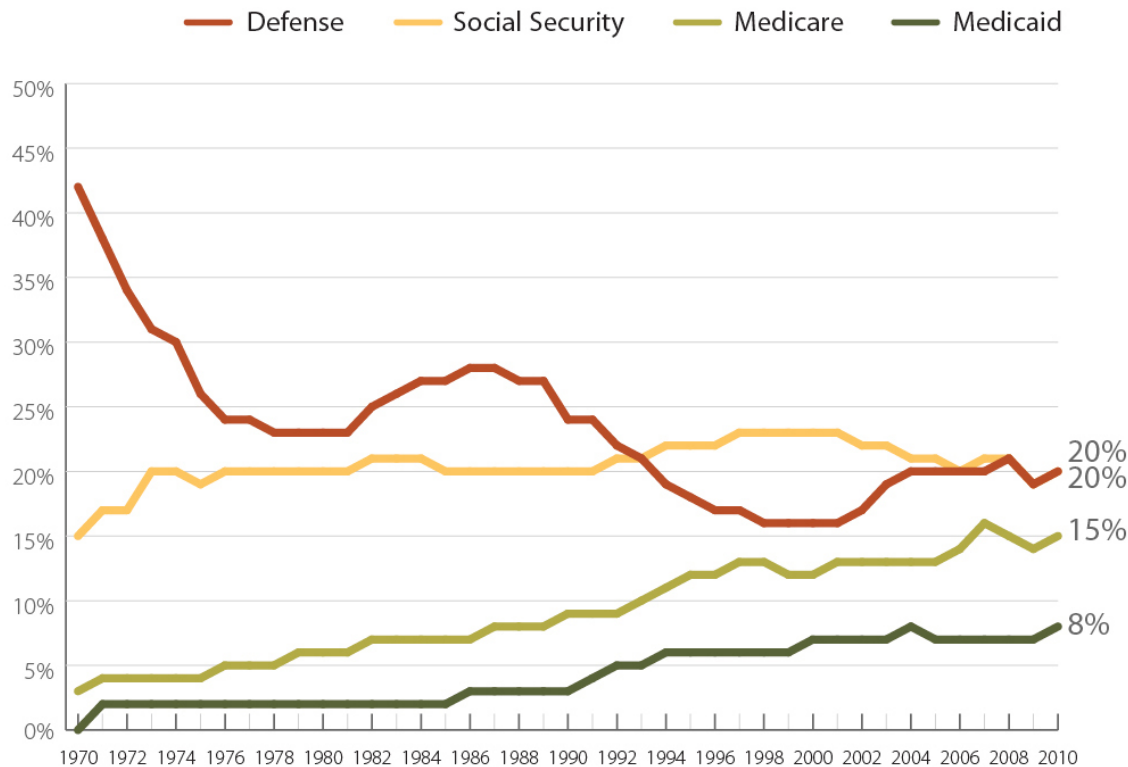
In each of those years real GDP grew (3.1%), 2.4% and 1.8%

Dramatic Growth in Medicaid Spending

Historical and projected Medicaid expenditures and annual growth rates, FYs 1966-2020



Major Programs as a Share of the Federal Budget



Notes: Spending shares computed as percentage of federal outlays. All outlays reflect federal spending only (i.e., Medicaid outlays shown reflect federal portion of Medicaid).
Sources: Centers for Medicare and Medicaid Services (CMS), Office of the Actuary, National Health Expenditure Data, 2012 release. Congressional Budget Office, *The Budget and Economic Outlook: Fiscal Years 2012 to 2020*, January 31, 2012, Appendix F, "Historical Budget Data," www.cbo.gov.

Health care spending on Medicaid and Medicare now consumes 23% of the federal budget

50.9% of federal revenues for Medicaid and Medicare compared to 23% of the federal budget

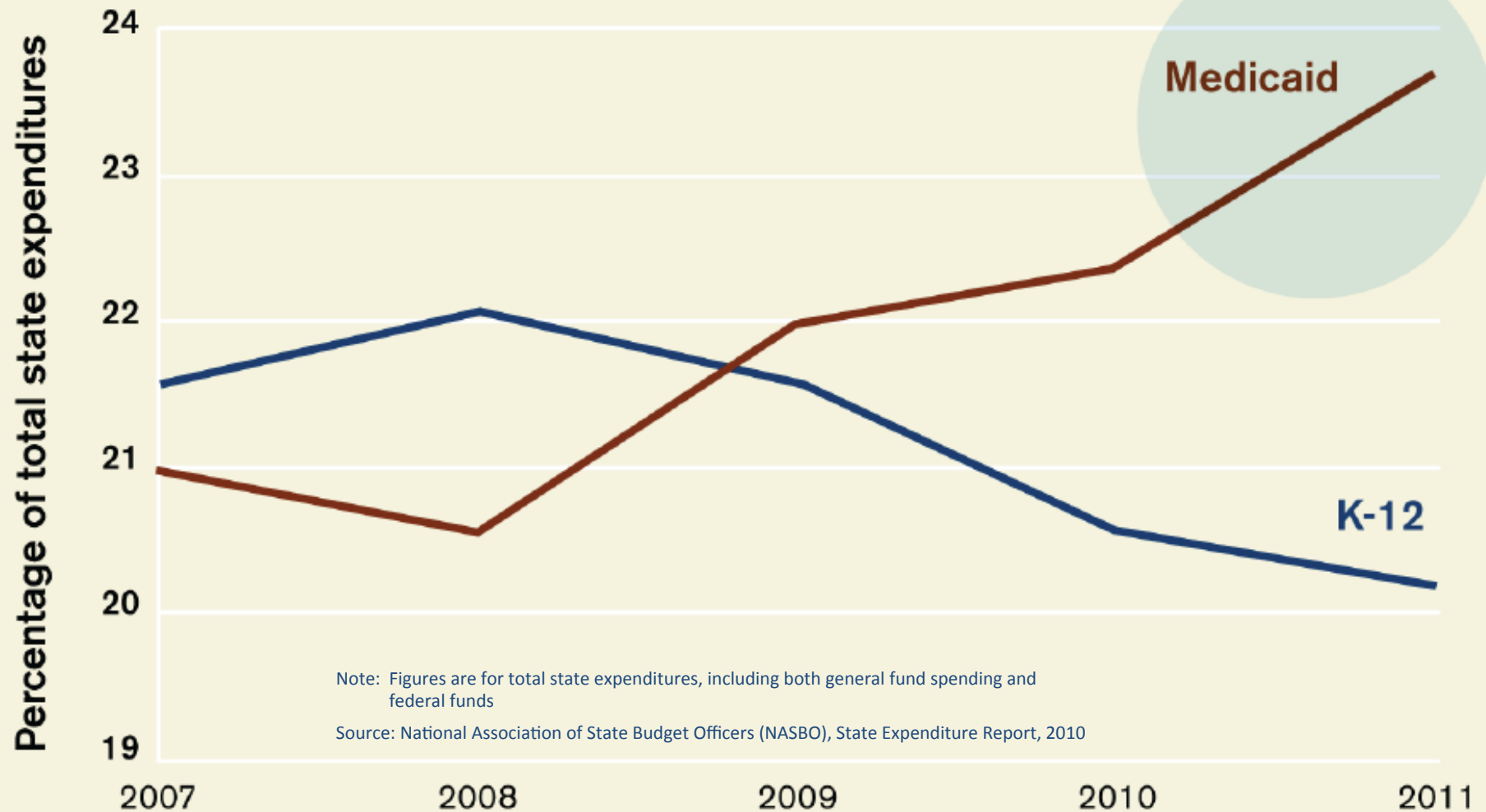
The fine print: "due to borrowing, federal government revenues are less than outlays"

Medicaid expansion is borrowed money

Total State Spending on Medicaid Now Surpasses K-12 Education



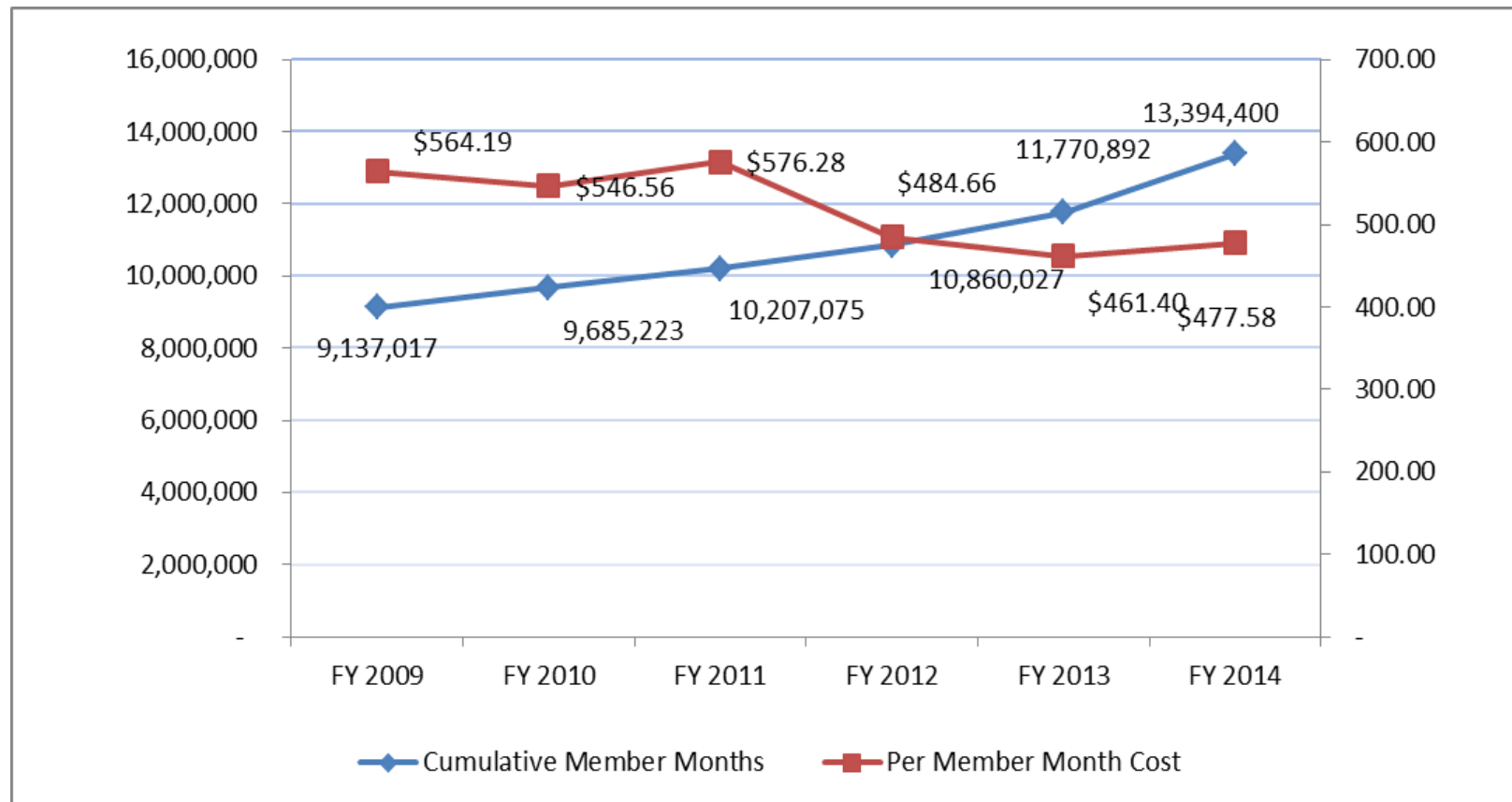
Medicaid and K-12 spending



South Carolina Medicaid



Comparison of Cumulative Member Months to Costs



Source: Milliman Spring 2013 Forecast and Department budget documents

8/13/2013

\$765 Billion Excess Cost in 2009

- \$100 billion more than the entire US defense budget
- Sufficient to fully pay health insurance premiums for 150,000,000 people
- 1.5 times the total 2004 national infrastructure investment including roads, railroads, aviation, drinking water, telecommunications and other structures



The Institute of Medicine's Six Domains of Excess Cost

- *Unnecessary services (\$210 billion)*
- *Administrative waste and duplication (\$190 billion)*
- *Inefficient services (\$130 billion)*
- *Prices that are too high (\$105 billion)*
- *Fraud (\$75 billion)*
- *Missed prevention opportunities (\$55 billion)*

Triple Aim

- Reduce per Capita Cost of Health Care
- Improve the Health of Populations
- Improve the Patient Experience
 - Quality and Satisfaction

“To address the lackluster health outcomes and unsustainable health care expenditures of the United States, a critical first step is to focus national efforts by setting a national target for health system performance on two key measures: *longevity* and *per capita health spending*.”

– “*For the Public’s Health: Investing in a Healthier Future*”
Institute of Medicine, April 2012



Health Services Are Not a “Market”



*“When we debate health care policy, we seem to jump right to the issue of who should pay the bills, blowing past what should be the first question: **Why exactly are the bills so high?**”*

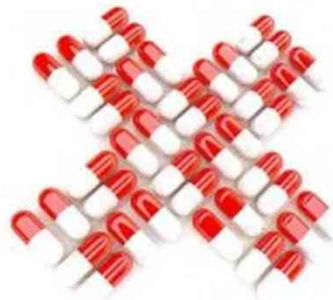
“the American health care market has transformed tax-exempt ‘nonprofit’ hospitals into the towns’ most profitable businesses...”

“the health-care-industrial complex spends more than three times what the military-industrial complex spends in Washington”

“the bills they churn out dominate the nation’s economy and put demands on taxpayers to a degree unequalled anywhere else on earth”

CATASTROPHIC CARE

HOW AMERICAN
HEALTH CARE
KILLED MY FATHER—
AND HOW
WE CAN FIX IT



DAVID GOLDHILL



“Medical care, of course, is merely one component of our overall health.”

“As a nation, we now spend almost 18 percent of our GDP on health care.”

“...the federal government spends eight times as much on health care as it does on education, 12 times what it spends on food aid to children and families, 30 times what it spends on law enforcement... Education, public safety, environment, infrastructure—all other public priorities are slowly devoured by the health-care beast.”

“Health insurance is the primary payment mechanism not just for expenses that are unexpected and large, but for nearly all health-care expenses.”

Health Insurance



***Access to Effective* Health Services**

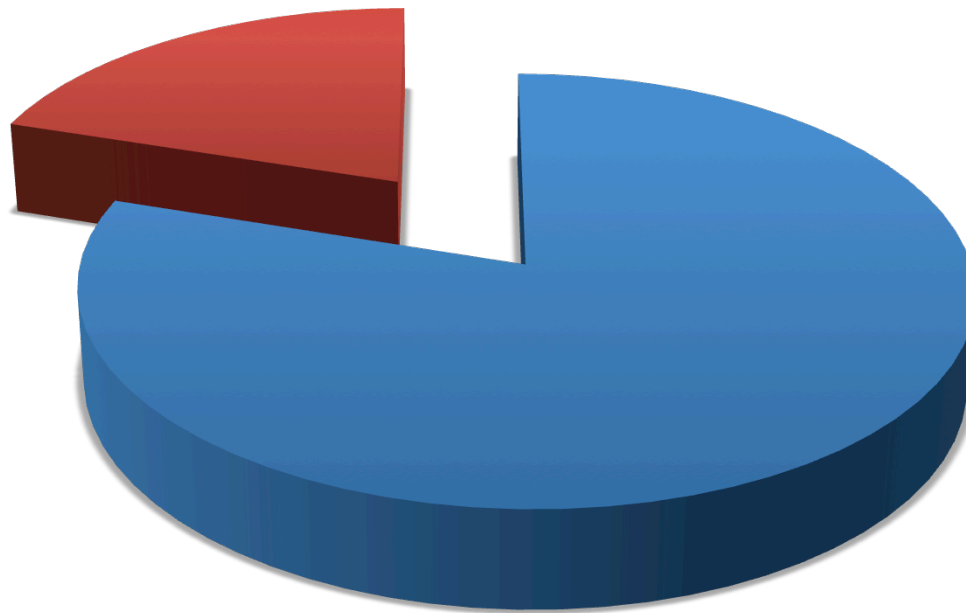


Health & Well-Being

The Reality



Health and Well-Being



■ Social Determinants

■ Health Services

Important Factors Contributing to Health:

- *Education*
- *Environment*
- *Individual behaviors
(diet, exercise)*
- *Biology & genetics*
- *Health services*

- “Many people believe that medical care and individual behaviors...are the primary reasons for the declines in health.”
- “But socioeconomic factors such as the percentage of a county’s population with a college education and the rate of children living in poverty had equally strong or stronger relationships to...mortality rates”

US is Falling Behind in Life Expectancy



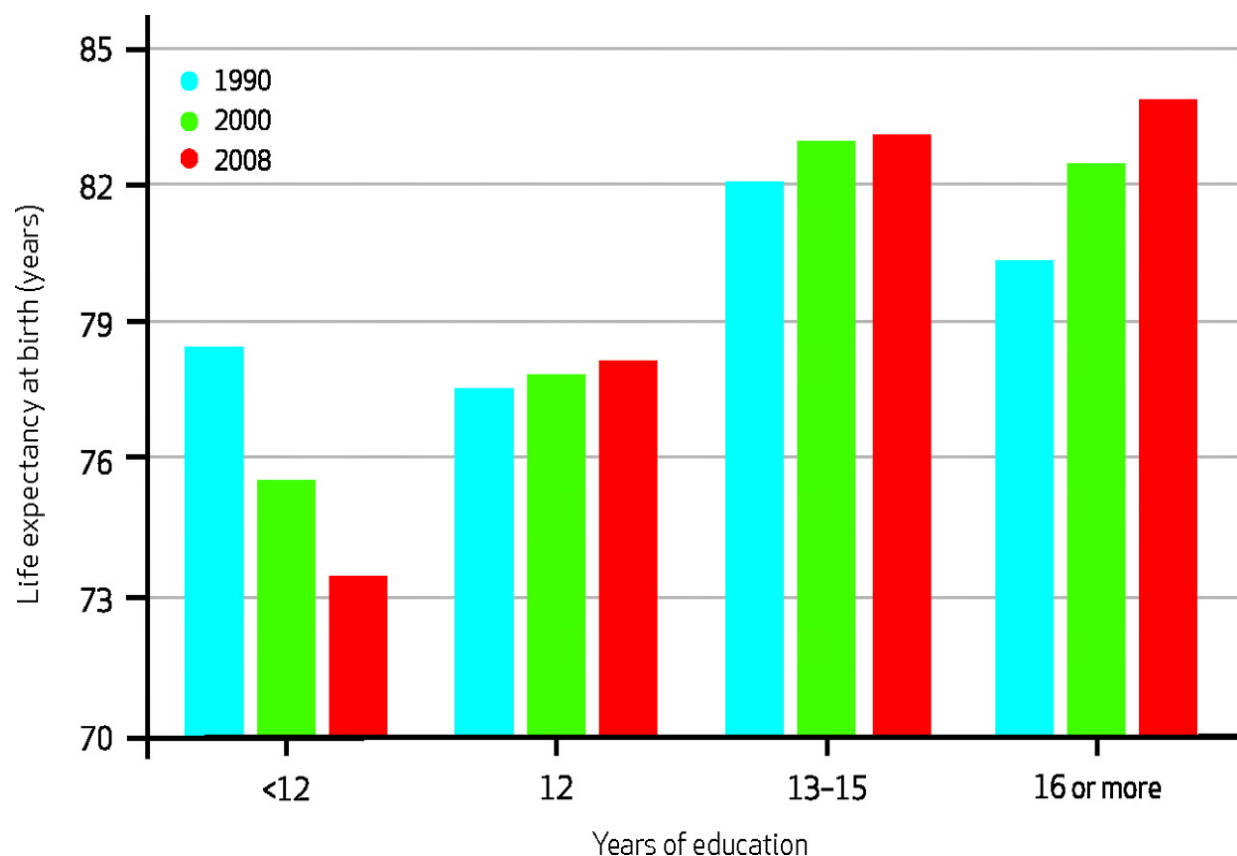
In 1950 US life expectancy ranked 12th at 68.9 years

In 2009 the US ranked 28th at 79.2 years

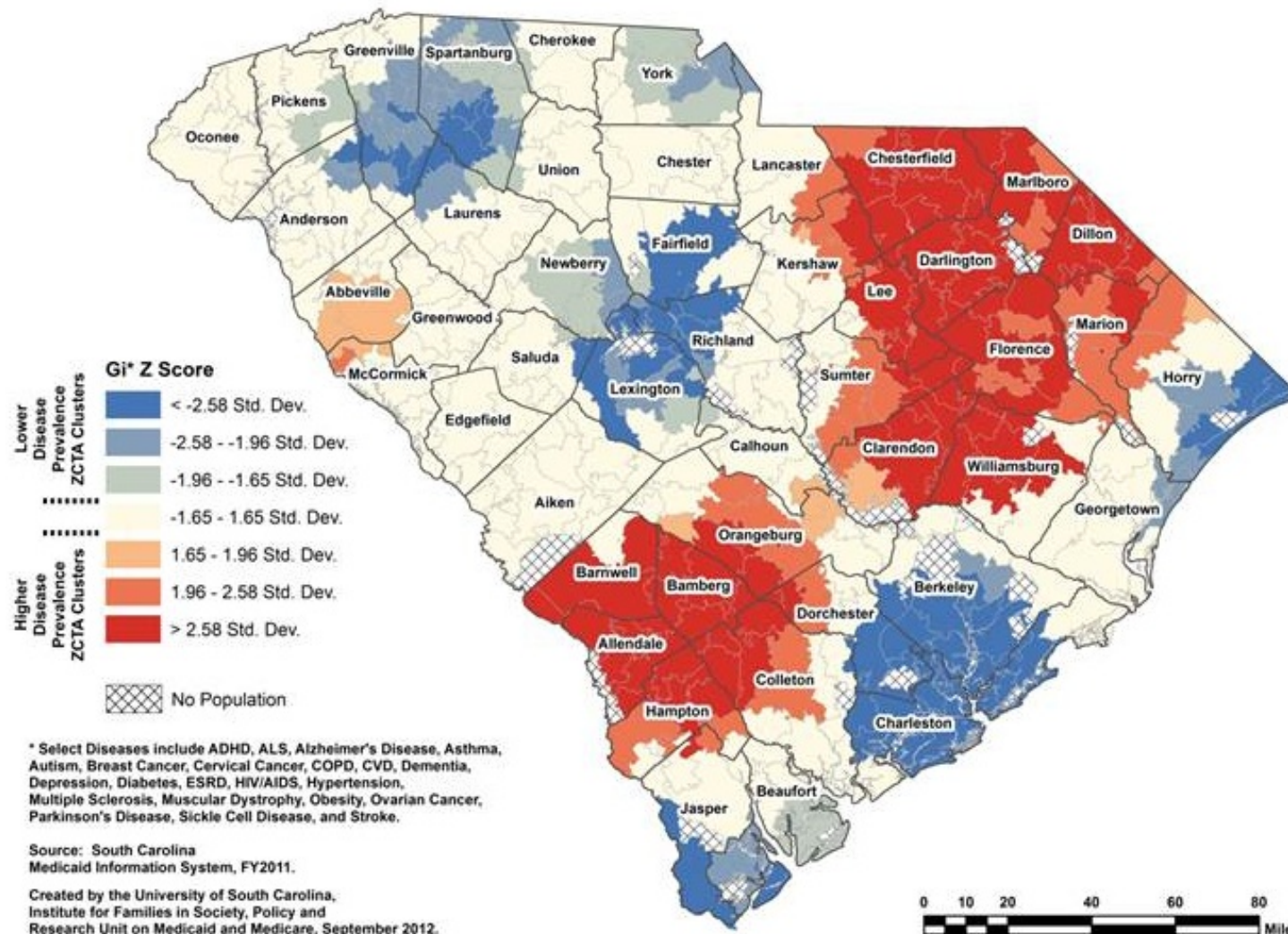
South Carolina ranked 42nd in US in 2007 at 76.6 years

Disturbing disparities exist and for certain groups life expectancy has actually fallen in the past two decades

Life expectancy for white women by years of education



**Prevalence of Select Diseases* Among South Carolina Medicaid Recipients
19 Years and Older by ZCTA, FY 2011
Getis-Ord Gi* Statistic (Hot Spot Analysis)**



What are We Paying for in SC Medicaid?



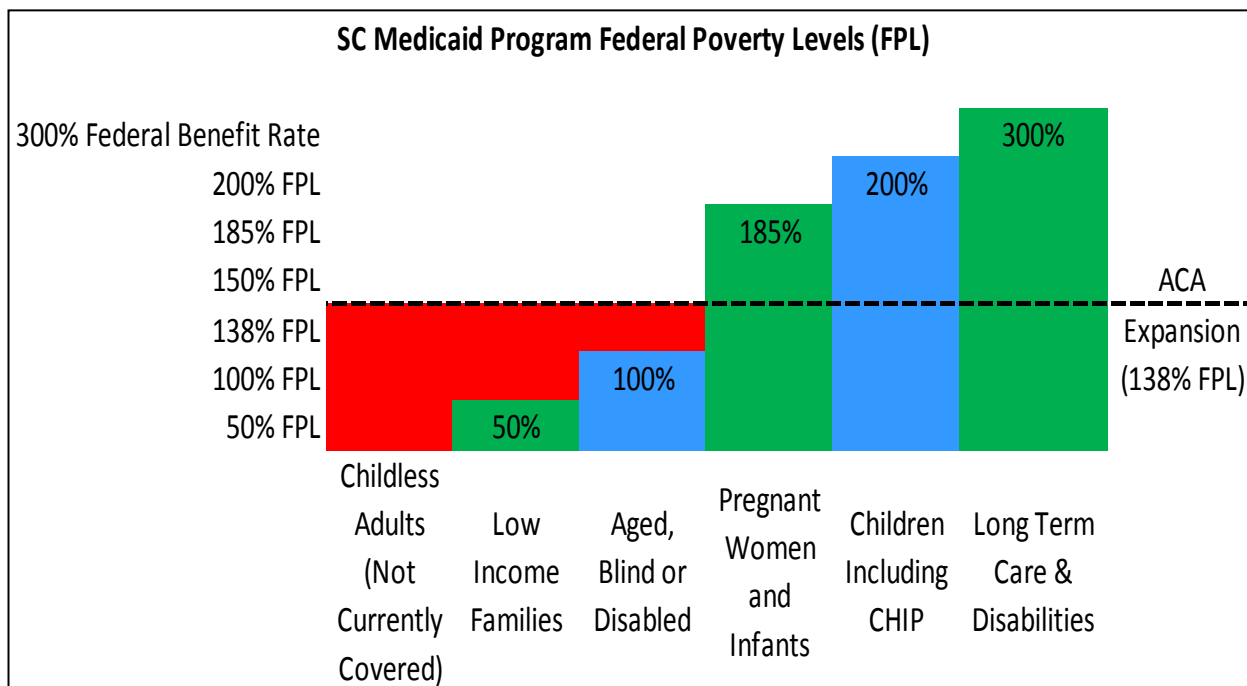
Percentage of Eligible Medicaid Beneficiaries Meeting Standard				
Measure	FFS	State Avg	Best Plan	NCQA Mean
Adolescent Well Care Visits	8.1	24.3	36.0	48.1
Lead Screening in Children	40.9	46.2	55.6	66.2
Breast Cancer Screening	28.5	43.3	53.9	51.3
Diabetic Eye Exams	10.5	27.1	41.5	53.1

* Source: CY 2011 SC Medicaid HC Performance Repot

What should we do?

- Meet the commitments of our current Medicaid program in South Carolina
- Deliver the greatest health value for the investments we are making
- Drive innovation within the health care services industry

Medicaid Expansion in SC: 513,000 New Enrollees by 2015



Without Medicaid Expansion:

- 101,000 may drop private insurance
- 162,000 currently eligible but may enroll in Medicaid (Welcome Mat Effect)

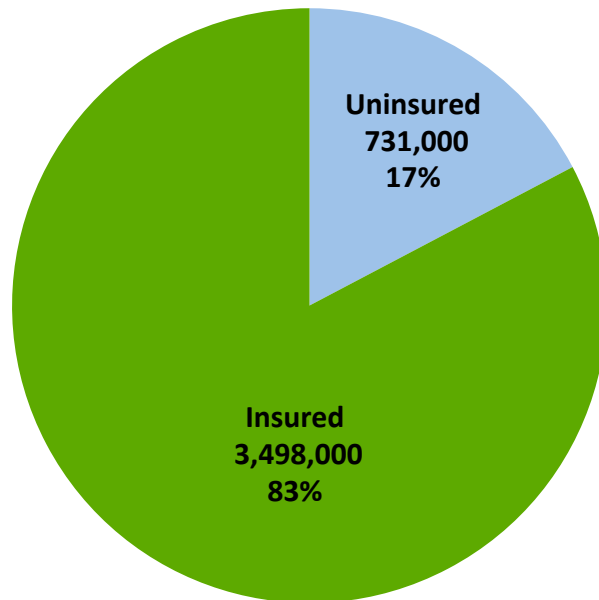
With Medicaid Expansion:

- 193,000 could drop private insurance to go on Medicaid
- 344,000 people will become newly eligible for Medicaid

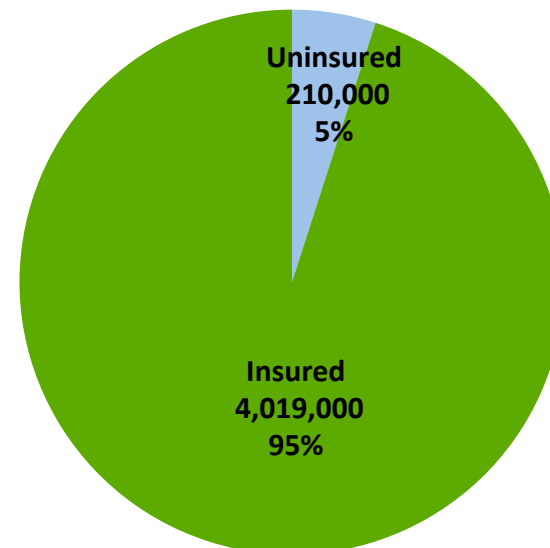
Even Without Medicaid Expansion, SC's Uninsured is Reduced 71%



Pre-ACA: 2013 Uninsured



**Post-ACA: 2015 Without Access
to Affordable Health Insurance**



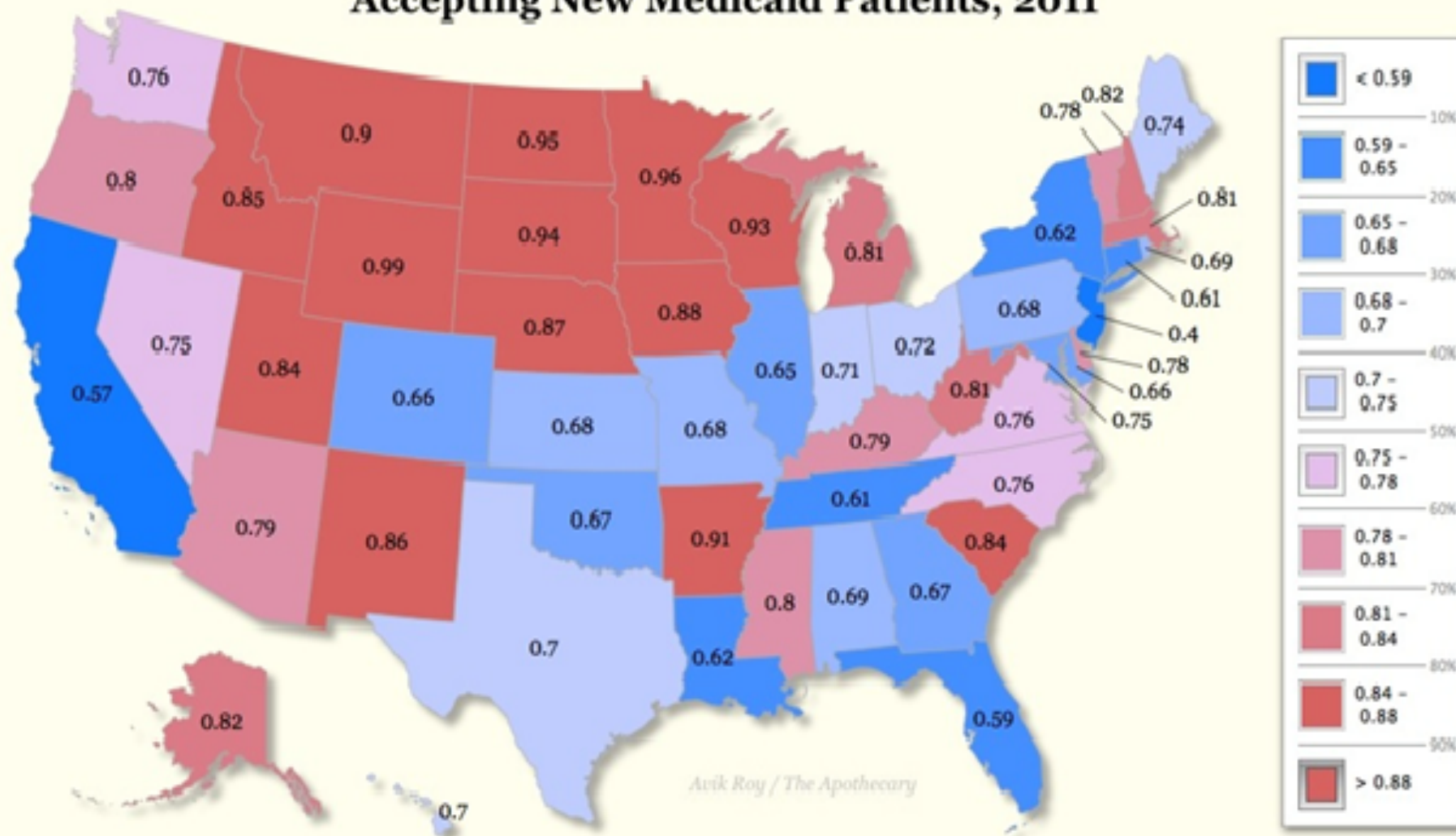
By 2015

Over half a million people will gain access to affordable health insurance coverage as defined under the new health care law, even without Medicaid expansion

The system will have a difficult time absorbing this growth – it may require between 250-300 full-time physician equivalents

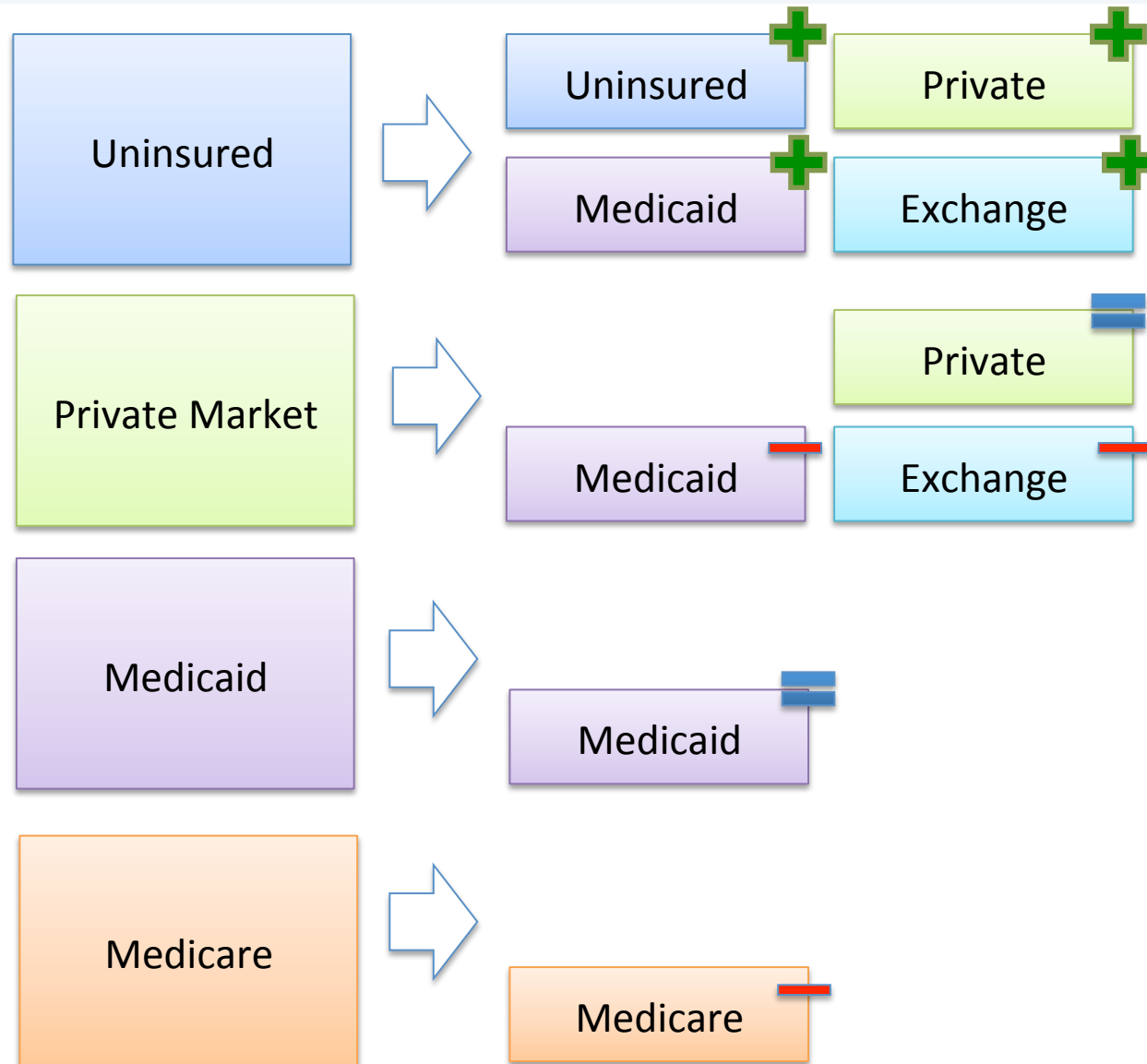
Percentage of US Office-Based Physicians Accepting New Medicaid Patients

**Percentage of U.S. Office-Based Physicians
Accepting New Medicaid Patients, 2011**



Avik Roy / The Apothecary

Shifting Payor Mix Under ACA



What percent of cost do current and future payor types cover?

How many lives will shift?

How does utilization change by payor type?

How does ACA affect patient out of pocket?

What dynamics will change related to payment and coverage at time of service?

Organic Growth In Health Care is Depressing Other Sectors

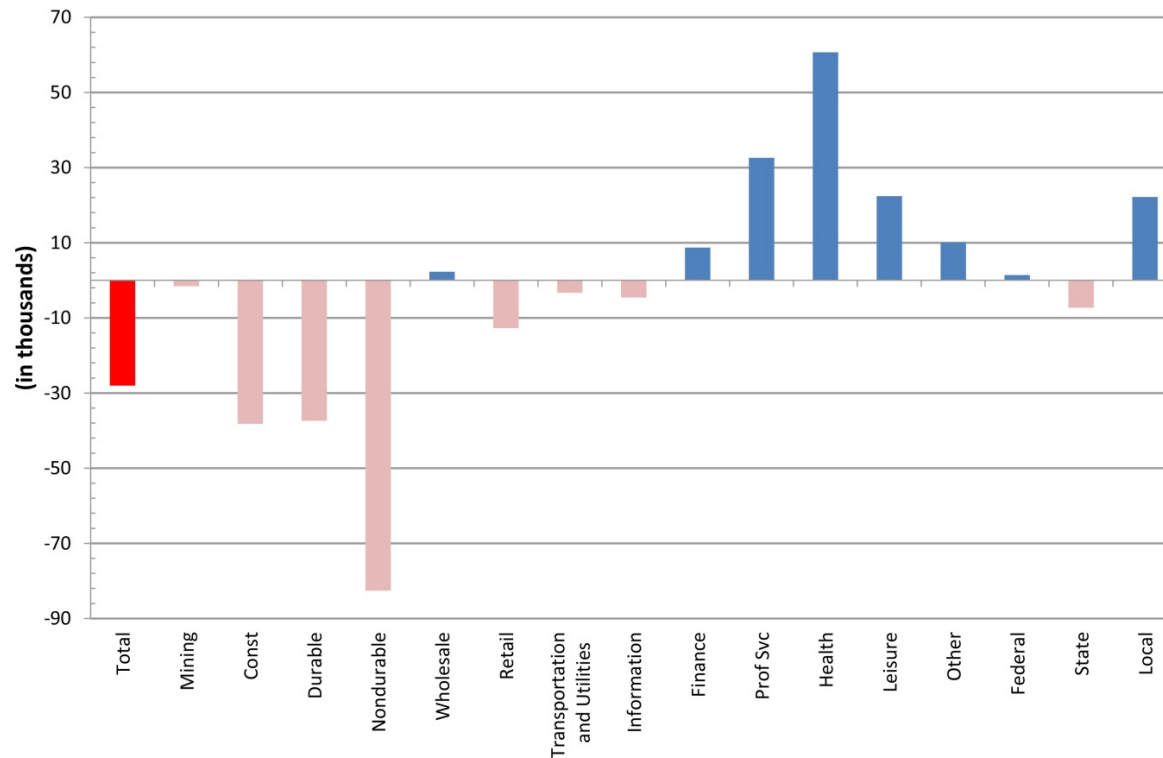


According to South Carolina's BEA, from 2000-2011, growth in health jobs was about twice the number of the second largest sector (professional services)

The health sector grew by more than 60,000 jobs during that time, while more than half the sectors had negative job numbers growth

After SC Medicaid rate cuts, health care jobs in SC increased several thousand from 153,400 in April 2012 to 160,600 in October 2012

SC Employment Growth by Sector
2000-2011 Number of Jobs



Source: Board of Economic Advisors (BEA)

Health Care Business Model Must Change



Value

Borders
USPS
Ma Bell

Amazon/Kindle
Google/FedEx
AT&T/Virgin Mobile

Time

Move from fee-for-service that drives market share growth and utilization to population management

Transparency in pricing and outcomes for consumers to make better decisions

Remove barriers to competition at all levels

Focus on total costs which requires clinical integration and more focus on social determinants

Consumer must share more cost – we are overinsured and too separated from the consequences of our actions

Insurance Exchanges, Medicaid and the Uninsured

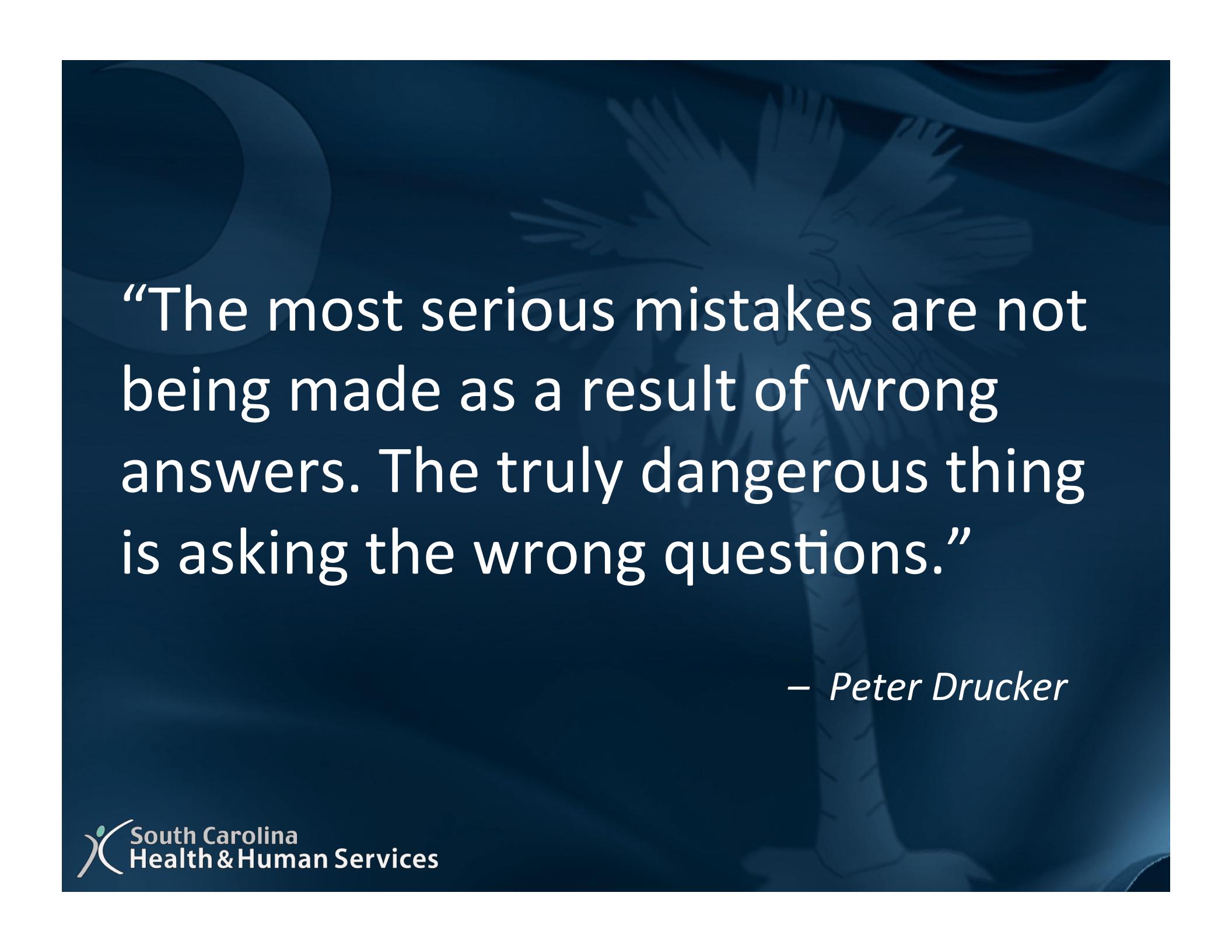
- Access to Federal Health Insurance Exchange using the Federally Facilitated Marketplace (FFM, was Federally Facilitated Exchange/FFE)
- SC Citizens will be able to “start” with the Federal Marketplace/Exchange or with State/Medicaid – new online application
- Subsidized health plans eligible based on income and FPL 100%-400%
- Available through www.healthcare.gov

- SC Department of Insurance estimates rise in insurance premiums in individual and small group markets
 - Guaranteed issue (includes pre-existing conditions)
 - Qualified Health Plan (QHP) and essential benefits
 - Coverage of children through age 26
 - 80/20 rule for medical loss ratio (MLR)
- Four carriers have submitted plans to sell on the federal exchange in South Carolina

- www.healthcare.gov (800.318.2596)
- In-person Assistance in South Carolina
 - Insurance brokers and agents
 - Navigators
 - Consumer assistance counselors
- Small Business Health Options Program (SHOP)
 - Employer mandate delayed for one year (until 2015)
 - Small businesses with less than 25 employees may be eligible for small business health care tax credit

- Continue working on improving value in the health system
 - Focus on identifying and coordinating care for the uninsured
 - Set performance expectations
 - Strengthen core programs
- Manage and measure enrollment growth and shifts under ACA
- Invest in health hotspots and building capacity
- Apply for flexibility in 2017 when ACA waivers are available

- Development of Healthy Outcomes Plans to coordinate care for the uninsured
 - Federally Qualified Health Centers (FQHCs), Rural Health Centers (RHCs), Free Clinics and Hospitals
- Greater accountability in use of Medicaid DSH
- Increased transparency in patients served, health pricing and health quality
- SCDHHS working to implement requirements of Proviso 33.34



“The most serious mistakes are not being made as a result of wrong answers. The truly dangerous thing is asking the wrong questions.”

– *Peter Drucker*